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This week in the BMJ

When is a disease a "non-disease"?

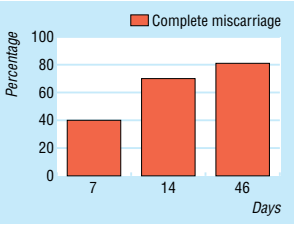
Top 10 non-diseases
(in descending order of non-diseases)

1. Ageing
2. Work
3. Boredom
4. Bags under eyes
5. Ignorance
6. Baldness
7. Freckles
8. Big ears
9. Grey or white hair
10. Ugliness

A recent vote on bmj.com to identify "non-diseases" found almost 200, some of which already appear in official classifications of disease. Smith (p 883) argues that to have your condition labelled as a disease may bring considerable benefit, but the diagnosis may also create problems—you may be denied insurance, a mortgage, and employment. He says that everything is to be gained and nothing lost by raising consciousness about the "slipperiness of the concept of disease."

Women opt for expectant management of miscarriage

In an observational study of 1096 consecutive patients with a suspected first trimester miscarriage, Luise and colleagues (p 873) found that 70% of women chose expectant management when it was offered, rather than electing for immediate surgical removal of retained products identified by transvaginal ultrasonography.



Eighty one per cent went on to complete their miscarriage without the need of intervention. The authors conclude that patients should be encouraged to persevere with expectant management, and they call for more research to validate the use of ultrasonography in defining an outcome measure for complete miscarriage.

Many junior doctors experience bullying

Many junior doctors in the United Kingdom experience bullying during training. Of 594 doctors surveyed, 37% reported being bullied in the past year. Black and Asian doctors were more likely to be bullied than white doctors, and women were more likely to report bullying than men. Quine (p 878) says that although these findings should be interpreted cautiously, the disturbingly high levels of bullying and mistreatment during training are part of many junior doctors' perceptions and experiences.

Longer consultations are better for patients

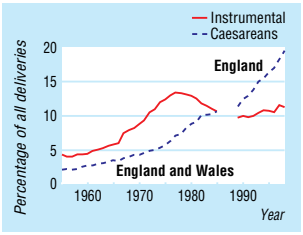
Doctors who give longer consultations prescribe less, offer more lifestyle advice, handle psychosocial problems better, and empower patients. A systematic review of 14 research papers by Freeman and colleagues (p 880) also found that the most effective consultations were those in which doctors directly acknowledged and responded to patients' problems and concerns. The authors say that 15 minutes is barely adequate to see and examine an elderly patient with several active problems. Longer consultations should be a professional priority, and ways to introduce them should be found.

Action is needed to stop "disease mongering"

CHRIS GROENHOUT

Some forms of medicalising of ordinary life may be better described as "disease mongering." They include turning ordinary ailments into medical problems, seeing mild symptoms as serious, treating personal problems as medical ones, and seeing risks as diseases. Moynihan and colleagues (p 886) believe that more could be done to expose and reduce misleading "wonder drug" stories which help to promote so much disease mongering. They maintain that corporate funded information about disease should be replaced by independent information.

Obstetricians have medicalised childbirth



Johanson and colleagues (p 892) argue that there is a growing trend of obstetric intervention in childbirth; this is associated with increasing medicolegal pressures, and women are not involved in decision making. Obstetricians have now taken over responsibility for normal births, in addition to their role in complicated births. Caesarean rates in Britain have now reached 20% and

obstetricians, the authors say, must be held accountable. If this trend is to be reversed then the "blame and claim" culture should be addressed, and childbirth without fear should become a reality for women, midwives, and obstetricians alike.

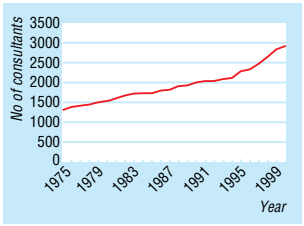
Medicalising sex damages relationships

NLM

Medicine has long been exercising its authority over sexual behaviour and in an increasingly secular society definitions of what is morally acceptable now fall to medical science. Hart and Wellings (p 896) examine the increasingly medical approach to sex, which they say ignores the social and interpersonal dynamics of relationships. They argue that the medicalisation of sex has resulted in the use of surgery and drugs to enhance sexual pleasure and that our obsession with sexual gratification increases expectations and feelings of inadequacy.

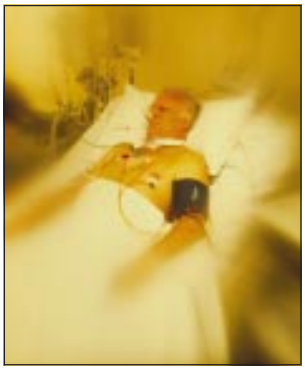
The time has come for "post-psychiatry"

Modern psychiatry encourages a biomedical model that encourages drug treatment to be seen as a panacea for multiple problems. Antidepressant prescription rates have increased alongside the number of consultants in psychiatry, which have been



rising steadily. Double (p 900) is sceptical of this approach and questions the legitimacy of psychiatric interventions for common personal and social problems. He says that psychiatry should return to a biopsychological view and recognise the uncertainties of clinical practice. Such an approach has been called "post-psychiatry," which emphasises social and cultural contexts, places ethics before technology, and works to minimise medical control.

Is a good death now a medical death?



SPL

The development of palliative care began in the 1950s, when concerns were voiced over the apparent neglect of dying people. Research, a greater openness about terminal conditions, and a more active approach to the care of the dying person have all developed since then. The term "palliative care," first proposed in 1974, came to symbolise this broadening orientation. Yet the charge of creeping medicalisation has, considers David Clark (p 905), now been levelled at palliative care. All doctors now face the problem of balancing technical intervention with a humanistic orientation to their dying patients.

Editor's choice

Postmodern medicine

Uwe Reinhardt, perhaps America's funniest economist, spoke some years ago of what might happen as spending on health care ate up ever larger chunks of gross domestic product. Coast to coast America would become one enormous hospital, with everyone either working in health care or being ill (or both). Reinhardt might therefore appreciate this issue on medicalisation—which discusses much the same problem but from a doctor's eye view, rather than an economist's.

Not that economists don't get a look in. Amartya Sen, an even more distinguished economist, discusses the paradox that people in America feel much less well than those in Bihar, India, though their life expectancy is much better (p 860). Indeed, a direct relation seems to exist between self reported morbidity and life expectancy. He uses this example to caution against assuming that patients' perceptions should always trump those of experts.

But the shadow that really hangs over this issue is that of Ivan Illich—author of *Medical Nemesis* and *Limits to Medicine* (reviewed, along with other old classics, on p 923). His argument, explained in the opening editorial (p 859), is that modern medicine has become a threat to health by undermining the capacity of individuals and societies to cope with death, pain, and sickness.

It's also a diversion of resources. And here the pharmaceutical industry comes in for particular criticism. Ray Moynihan and colleagues accuse it of "extending the boundaries of treatable disease to expand markets for new products" (p 886). Barbara Mintzes echoes this in her argument against direct to consumer advertising of drugs (p 908). In 1999 Americans saw an average of nine prescription drug adverts a day on television, portraying the dual message of a pill for every ill—and "an ill for every pill." Nevertheless, Silvia Bonaccorso and Jeffrey Sturchio manage a spirited defence of "liberalised direct to consumer information" (p 910).

Indeed, this issue isn't all one sided. Shah Ebrahim asserts that the medicalisation of old age should be encouraged because treating the health problems of older people is effective and attempts to ration care on the grounds of age are unfair (p 861).

And though doctors are accused of encouraging or at least colluding in medicalisation, the alternative view that doctors are just as much its victims is also prominent. "The bad things of life: old age, death, pain, and handicap are thrust on doctors to keep families and society from facing them," say Leonard Leibovici and Michel Lièvre (p 866). "There is a boundary beyond which medicine has only a small role." When doctors are forced to go beyond it "they do not gain power or control: they suffer."

That might suggest that Illich has won the argument. Indeed, David Clark, in his article on the "postmodern specialty" of palliative medicine, thinks he has (p 905). In the 1970s he says, there was a "much more unitary and optimistic view of medicine. Now the … system is pervaded with doubt, scepticism, and mistrust."

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